# DEFINING BASIC SERVICES AND DE-INSURING THE REST: THE WRONG DIAGNOSIS AND THE WRONG PRESCRIPTION

**Michael M. Rachlis, MD, MSc, FRCPC**


## Abstract • Résumé

The Canada Health Act of 1984 requires the provinces to cover all "medically necessary" services in order to be eligible for full federal contributions. However, neither the federal government nor any province has operationally defined the term "medically necessary service." As a result, coverage of certain medical services across the country is uneven. There is even greater variation in the coverage of nonmedical services (such as drugs and home care) that are not included in federal legislation. Recently, several provincial medical associations, with their respective provincial governments, have agreed to define and cover basic services and to de-insure services not found to be "medically necessary." The author argues that this process makes the wrong diagnosis of the cause of the woes of our health care system and then issues the wrong prescription. It also distracts decision makers from more worthwhile policies to reform the health care system.

La loi canadienne sur la santé de 1984 oblige les provinces à couvrir tous les services «médicalement nécessaires» pour avoir droit en entier aux contributions fédérales. Or, ni le gouvernement fédéral, ni les provinces n'ont formulé de définition opérationnelle de l'expression «services médicalement nécessaires». C'est pourquoi la couverture de certains services médicaux n'est pas uniforme au Canada. La couverture des services non médicaux (comme les médicaments et les soins à domicile) qui ne sont pas inclus dans la loi fédérale l'est encore moins. Récemment, plusieurs associations médicales provinciales ont convenu, avec le gouvernement de leur province respective, de définir et de couvrir les services essentiels et de désassurer les services qui ne sont pas jugés «médicalement nécessaires». L'auteur soutient que cet exercice pose le mauvais diagnostic de la cause des problèmes de notre système de santé et qu'on établit ensuite la mauvaise ordonnance. Cet exercice détourne aussi l'attention des décideurs de politiques valables de réforme du système de santé.


The Canada Health Act[1] outlines the terms and conditions provincial health insurance plans must meet to be eligible for full federal contributions. The act builds on previous federal legislation of health insurance, including the Hospital Insurance and Diagnostic Services Act[2] and the Medical Care Act.[3] All of these acts require the provinces to cover services that are "medically necessary" or "medically required." However, neither the federal government nor any province has operationally defined these terms.[4] As a result, coverage of certain medical services across the country is uneven.[5] For example, Ontario provides coverage for in-vitro fertilization for some patients whereas other provinces do not cover this service at all.

Several provincial medical associations and their respective provincial governments have recently agreed to define basic services to be covered and to de-insure services not found to be "medically necessary." These policy initiatives were inspired partly by the state of Oregon's decision to define basic services to be covered by its Medicaid program.[6]

However, defining basic services and de-insuring the rest makes the wrong diagnosis of the woes of our health care system and then issues the wrong prescription. This prescription will not heal the problems of the health care system, and it may involve potentially dangerous side effects. This article outlines the problems associated with diagnosing a lack of definition of basic services as the cause — even the partial cause — of the symptoms of our health care system and offers a critique of the prescription for de-insurance. Finally, I offer a brief overview of alternative policy remedies.

*Dr. Rachlis is in the Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, Ont.*

***Correspondence to:*** *Dr. Michael M. Rachlis, 13 Langley Ave., Toronto ON M4K 1B4; fax 416 466-4135*

← For prescribing information see page 1528

## WHAT'S WRONG WITH THE DIAGNOSIS?

Is the lack of a definition of basic services a major problem with Canada's health care system?

The policy recommendation of a definition of basic services implies two faulty assumptions about the problems besetting Canada's health care system: there are many health care services that we can no longer afford to cover with public health insurance, and there are relatively few problems with the appropriate delivery of services that should be covered.

### WHAT CAN WE AFFORD?

Some services appear to be completely ineffective or frivolous, but almost all services are appropriate for some patients in some situations. Even public-insurance coverage of tatoo removals could easily be justified in certain circumstances. For example, consider a teenager who flees abuse at home, takes to the streets, becomes a drug addict and has a death's-head tatooed on her face. Suppose that, in her 20s, she undergoes drug rehabilitation and gets an education. After years of pain and thousands of dollars of publicly covered rehabilitation, she cannot get a job because of her disfiguring tatoo. Should medicare not pay for the tatoo's removal as part of her overall rehabilitation?

### ARE THERE FEW PROBLEMS WITH THE APPROPRIATE DELIVERY OF SERVICES?

This assumption implies that there is little pay-off in improving the appropriateness of service delivery compared with the savings from delisting services now covered. These suppositions are more than slightly faulty. Recent reports on health care have consistently noted that inappropriate care is a major problem. For example, the Ontario Health Review Panel reported that "evidence of inappropriate care can be found throughout the Province's health care system, from inappropriate institutional admissions to overuse of medications among the elderly."[7]

Commissions on health care in other provinces have come to similar conclusions.[8,9] It is relatively simple, in retrospect, to determine that a particular diagnostic test or therapy has not helped an individual patient; however, an inappropriate service is one that (1) can be predicted to be of no net benefit to the patient on the basis of the best scientific evidence available, or (2) can be predicted to be likely of some net benefit but no more so than a test or therapy that is less expensive.

On the basis of this definition, there is substantial evidence that inappropriate services are being provided. Studies have shown significant differences in the rates of delivery of certain services among geographic areas despite the similar health status of the populations in these areas.[10–13] The best explanation for the variation is often the number of physicians in each area and the procedures they prefer, instead of differences in rates of illness or patient preferences concerning treatment.[14] A large proportion of services are labelled as inappropriate by expert panels convened to define standards of care for particular episodes of illness.[15,16]

Several studies in Canada[17,18] and the United States[19,20] have shown that fee-for-service remuneration is associated with overall health care costs 25% to 40% higher than those under other methods of payment. The most comprehensive study of this kind was the Rand Health Insurance Experiment.[19–21] In one part of this experiment, more than 1600 patients were randomly assigned to receive their health care from either the Group Health Cooperative of Puget Sound, Seattle, a non-fee-for-service health maintenance organization (HMO) or fee-for-service providers in the Seattle area. At the end of the experiment there were no overall differences in the health of the two groups of patients; however, there was a very large difference in costs. The mean costs for the patients attending fee-for-service physicians were 40% higher than those for the patients attending the HMO. This difference was due almost entirely to the 40% fewer days spent in hospital among patients in the HMO group.[19] However, it should be noted that there were some differences in the health of some subgroups (wealthy, sick patients had better health outcomes in the HMO group, whereas poor, sick patients fared better in the fee-for-service system), and the patients attending the HMO were less satisfied with their care.[21]

Furthermore, when consumers are allowed to make informed choices about their care, they often choose services different from those chosen when the options for care are presented in a traditional fashion. For example, many frail elderly and terminally ill patients would choose effective symptom control rather than curative care; however, this option may not be presented. A study conducted in Hamilton, Ont., demonstrated that the use of advance directives in the care of residents of a home for the aged led to more appropriate and less intensive care for the dying, including a 50% reduction in the use of hospital services.[22,23] Research has shown that at least part of this inappropriate care may be due to poor patient–physician communication.[24,25]

Many medical services could be provided by nonphysicians, such as nurses, at less cost and, sometimes, with improved quality.[26–30] Family physicians and emergency physicians spend much of their time treating patients with minor illnesses that they could be taught to manage themselves.[31–33]

## What's wrong with the prescription for de-insurance?

Not only is the diagnosis of a lack of defined basic services based on faulty assumptions, but there are also problems with the proposed prescription for a cure. The process of defining basic services and then delisting the rest is very difficult to conduct scientifically; there is little money to be recouped; and it distracts policy makers from more important health care issues. Paradoxically, if policy makers dealt with some of these issues, there would be less need to consider de-insurance.

### Which services should be covered?

It is extraordinarily difficult to establish which services should be covered; it would be more useful to determine which outcomes should be achieved. The values assigned to various outcomes by individual patients or Canadian society are much less subject to change than the technical processes (i.e., services) for achieving them. As research progresses and technology changes, a health care system that is restricted to paying for certain services will result in increasingly ineffective and inefficient health care. For example, coronary artery bypass grafting is effective in reducing angina in patients with disease in one or two vessels that does not involve the left main or proximal left anterior descending coronary arteries;[34] however, it is more dangerous and probably less efficient than intensive cardiac rehabilitation,[35,36] which is not fully covered by public insurance. Provincial governments could facilitate more effective and efficient systems by identifying the desired outcomes of health care instead of simply enumerating the specific services they will reimburse. In the United States a group of HMOs and private insurers have formed the HMO Quality of Care Consortium, which is developing standardized outcome indicators for health programs.[37]

### What is the pay-off in defining basic services and delisting the rest?

In 1993–94 the Ontario government and the Ontario Medical Association went to considerable effort and expense to identify eight services to be delisted,[38] thereby saving between $8 million and $16 million for the Ontario Health Insurance Plan (Mary Fleming, Provider Services Branch, Health Insurance and Related Programs, Ontario Ministry of Health: personal communication, 1995). Without trivializing this sum, it should be noted that it represents only about 0.3% of the Ontario budget for physicians and less than 0.1% of the overall Ontario budget for health care.[39] On the other hand, Ontario spends approximately $200 million on payments to physicians for treating colds,[40] an amount that could easily be reduced through greater self-care and telephone access to a nurse.

### Does this process distract policy makers from more important health care reform?

The process of defining basic services risks distracting decision makers from the policies needed to develop a more effective and efficient health care system. And it does so in a way that is very socially divisive. Policy makers have only a limited amount of time and energy, which can easily be sapped by the emotionally draining exercise of deciding which Canadians have health problems that deserve insured treatment.

What we need is a discussion of the overall health outcomes to be achieved through publicly funded health services. Such a discussion could have a major effect, helping to steer the structure and process of care and services provided. Perhaps the most devastating effect that defining and delisting services could have on constructive policy making is the termination of such a discussion.

## Toward an accurate diagnosis and a long-term cure

The Ontario Health Review Panel has summarized the conclusions of many other Canadian reports on health care.

> Current submissions and earlier reports highlight the need to place greater emphasis on primary care, to integrate and coordinate services, to achieve a community focus for health and to increase the emphasis on health promotion and disease prevention.[41]

There are many methods other than de-insurance to improve the efficiency of health care services. In fact, the best way to decrease the use of questionable categories of services may be one that does not tackle the issue directly. For example, if most physician reimbursement were not on a fee-for-service basis, there would be much less need to focus on coverage of specific services. Another promising policy direction is the introduction of provider-friendly clinical quality-assurance programs. These programs would significantly improve the quality of health care and focus on more appropriate services.[42] Finally, provinces could eschew a discussion of delisting and de-insurance, choosing instead to engage their citizens in a dialogue concerning the overall health outcomes expected as a result of publicly funded health services. This policy direction could have a major effect on the development of more efficient delivery models. These kinds of policies are particularly necessary now, as

the provinces radically restructure the political and administrative framework for health care services.

## Conclusion

Provincial governments are under pressure to make their health care systems more efficient. However, if they feel that they must cut their funding of health care (a view open to legitimate debate), they could do so in a way that does not involve the definition of basic services and the denial of needed care. Canadian reports issued during the past decade have highlighted the need to restructure fundamentally the organization and financial incentives of the health care system. Policy makers need to pay more attention to these policy directions. Defining basic services and de-insuring the rest are the wrong prescription for what ails Canada's health care system.

## References


1. *Canada Health Act*, RS 1985, c C-6, s 3
2. *Hospital Insurance and Diagnostic Services Act*, RSC 1970, c H-8, as rep *Canada Health Act*, SC 1984, c 6, s 32
3. *Medical Care Act*, RSC 1970, c M-8, as rep *Canada Health Act*, SC 1984, c 6, s 32
4. *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies*, vol 1, Royal Commission on New Reproductive Technologies, Ottawa, 1993: 80
5. Deber R, Ross E, Catz M: *Comprehensiveness in Health Care*, Department of Health Administration, University of Toronto, Toronto, July 31, 1993
6. Harrison B, Noseworthy T: Is there a role for physicians in health and medical resource allocation? *Ann R Coll Physicians Surg Can* 1994; 27: 12–14
7. *Towards a Shared Direction for Health in Ontario*, Ontario Health Review Panel, Toronto, 1987: 31
8. *Report of the Commission on Selected Health Care Programs*, Commission on Selected Health Care Programs, Fredericton, 1989
9. *Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy*, Nova Scotia Royal Commission on Health Care, Halifax, 1989
10. Blais R: Variations in surgical rates in Quebec: Does access to teaching hospitals make a difference? *Can Med Assoc J* 1993; 148: 1729–1736
11. Naylor CD, Anderson GM, Goel V (eds): *Patterns of Health Care in Ontario: the Institute for Clinical Evaluative Sciences Practice Atlas*, vol 1, Canadian Medical Association, Ottawa, 1994
12. Sheps S, Scrivens S, Gait J: *Perceptions and Realities: Medical and Surgical Procedure Variation — a Literature Review*, [background paper], Conference of Deputy Ministers of Health, Department of National Health and Welfare, Ottawa, 1990
13. Health Services Research Group: Small area variations: What are they and what do they mean? *Can Med Assoc J* 1992; 146: 467–470
14. Wennberg JE, Freeman JL, Culp WJ: Are hospital services rationed in New Haven or over-utilised in Boston? *Lancet* 1987; 1: 1185–1189
15. Park RE, Fink A, Brook RH et al: Physician ratings of appropriate indications for six medical and surgical procedures. *Am J Public Health* 1986; 76: 766–772
16. Chassin MR, Kosecoff J, Park RE et al: Does inappropriate use explain geographic variations in the use of health care services: a study of three procedures. *JAMA* 1987; 258: 2533–2537
17. Hastings JEF, Mott FD, Barclay A et al: Prepaid group practice in Sault Ste. Marie, Ontario. *Med Care* 1973; 11: 91–103
18. *Community Clinic Study*, Saskatchewan Department of Health, Regina, 1983
19. Manning WG, Leibowitz A, Goldberg GA et al: A controlled trial of the effect of prepaid group practice in the use of services. *N Engl J Med* 1984; 310: 1505–1510
20. Ware JE, Rogers WH, Davies AR et al: Comparison of health outcomes at a health maintenance organisation with those of fee-for-service care. *Lancet* 1986; 1: 1017–1022
21. Davies AR, Ware JE, Brook RH et al: Consumer acceptance of prepaid and fee-for-service medical care: results from a randomized controlled trial. *Health Serv Res* 1986; 21: 429–452
22. Molloy DW, Guyatt GH: A comprehensive health care directive in a home for the aged. *Can Med Assoc J* 1991; 145: 307–311
23. Molloy DW, Urbanyi M, Horsman JR et al: Two years experience with a comprehensive health care directive in a home for the aged. *Ann R Coll Physicians Surg Can* 1992; 25: 433–436
24. Simpson M, Buckman R, Stewart M et al: Doctor–patient communication: the Toronto Consensus Statement. *BMJ* 1991; 303: 1385–1387
25. Beckman HB, Frankel RM: The effect of physician behavior on the collection of data. *Ann Intern Med* 1984; 101: 692–696
26. Spitzer WO, Sackett DL, Sibley JC et al: The Burlington randomized trial of the nurse practitioner. *N Engl J Med* 1974; 290: 251–256
27. Everitt DE, Avorn J, Baker MW: Clinical decision-making in the evaluation and treatment of insomnia. *Am J Med* 1990; 89: 357–362
28. Avorn J, Everitt DE, Baker MW: The neglected medical history and therapeutic choices for abdominal pain. *Arch Intern Med* 1991; 151: 694–698
29. Mitchell A, Watts J, Whyte R et al: Evaluation of graduating neonatal nurse practitioners. *Pediatrics* 1991; 88: 789–794
30. Brown SA, Grimes DE: *A Meta-Analysis of Process of Care, Clinical Outcomes, and Cost-effectiveness of Nurses in Primary Care Roles: Nurse Practitioners and Midwives*, Division of Health Policy, American Nurses Association, Chicago, 1992
31. Vickery DM, Kalmer H, Lowry D et al: Effect of self-care education program on medical visits. *JAMA* 1983; 250: 2952–2956
32. Roberts CR, Imrey PB, Turner JD et al: Reducing physician visits for colds through consumer education. *JAMA* 1983; 250: 1986–1989
33. Stergachis A: Use of controlled trial to evaluate the impact of self-care on health services utilization. *J Ambulatory Care Manage* 1986; 9 (4): 16–22
34. CASS principal investigators and their associates: Coronary artery surgery study (CASS): a randomized trial of coronary artery bypass surgery: quality of life in patients randomly assigned to treatment groups. *Circulation* 1983; 68: 951–960

35. Ornish D, Brown SE, Scherwitz LW et al: Can lifestyle changes reverse coronary heart disease? The lifestyle heart trial. *Lancet* 1990; 336: 129–133
36. Schuler G, Hambrecht R, Schlierf G et al: Regular physical exercise and low-fat diet: effects on progression of coronary artery disease. *Circulation* 1992; 86: 1–11
37. Siu AL, McGlynn EA, Morgenstern H et al: A fair approach to comparing quality of care. *Health Aff* 1991; 10 (1): 62–75
38. *Recommendations of the Joint Review Panel to the Joint Management Committee Re: the De-insuring of Medical Procedures*, Joint Review Panel, Ontario Ministry of Health, Toronto, 1994: 2–3
39. *Public Accounts in Ontario 1992–93*, vol 1, Ontario Ministry of Finance, Toronto, 1993: 4-237–4-239
40. Ontario Task Force on the Use and Provision of Medical Services: *1989–90 Annual Report*, Ontario Ministry of Health, Toronto, 1990: 11
41. *Towards a Shared Direction for Health in Ontario*, Ontario Health Review Panel, Toronto, 1987: i
42. Lomas J, Enkin M, Anderson GM et al: Opinion leaders vs. audit and feedback to implement practice guidelines: delivery after previous cesarean section. *JAMA* 1991; 265: 2202–2207

[redacted]

**May 17–20, 1995: Society for Obstetric Anesthesia and Perinatology 27th Annual Meeting**
Montreal
Society for Obstetric Anesthesia and Perinatology, PO Box 11086, Richmond VA 23230-1086; tel 804 282-5051, fax 804 282-0090

**May 18–19, 1995: The Centre for Health Economics and Policy Analysis 8th Annual Health Policy Conference — Jurisdictional Roles in Health Policy: Who's on First and What's Up Next?**
Toronto
Doris Hutchinson, Centre for Health Economics and Policy Analysis, Department of Clinical Epidemiology and Biostatistics, McMaster University, 1200 Main St. W, Hamilton ON L8N 3Z5; tel 905 525-9140, ext 22135; fax 905 546-5211

**May 20–25, 1995: American Psychiatric Association 148th Annual Meeting**
Miami
American Psychiatric Association, Division of Public Affairs, 1400 K St. NW, Washington DC 20077-1676; tel 202 682-6142, fax 202 682-6255

**Du 24 au 27 mai 1995 : 2e Conférence internationale sur la prise en charge extra-hospitalière des personnes vivant avec le VIH/SIDA : Les soins au sein des communautés (avec le co-parrainage de l'Organisation mondiale de la santé et la Fédération internationale des sociétés de la Croix-Rouge et du Croissant-Rouge)**
Montréal
*Crédits d'éducation médicale continue.*
Les services de congrès GEMS, 710–759 Square Victoria, Montréal QC H2Y 2J7; tél 514 286-0855, fax 514 286-6066

**May 24–27, 1995: 2nd International Conference on Home and Community Care for Persons Living with HIV/AIDS: Care Within Communities (cosponsored by the World Health Organization and the International Federation of Red Cross and Red Crescent Societies)**
Montreal
*Study credits available.*
Les services de congrès GEMS, 710–759 Victoria Square, Montreal QC H2Y 2J7; tel 514 286-0855, fax 514 286-6066

**May 25–28, 1995: Canadian Society for Transfusion Medicine and the Canadian Red Cross Society Joint Scientific Conference**
Edmonton
CSTM/CRCS Conference 1995, c/o Quandary Solutions, 5963–103 A St., Edmonton AB T6H 2J7; fax 403 438-4837

**May 26, 1995: 37th Annual Research Meeting of the Department of Ophthalmology, University of Toronto, and 15th Clement McCulloch Lecture**
Toronto
*Guest speaker: Dr. Clement McCulloch*
Dr. David S. Rootman, Department of Ophthalmology, University of Toronto, 1 Spadina Cres., Rm. 115, Toronto ON M5S 2J5; 416 369-5401, fax 416 978-1522

**May 26–27, 1995: Parent Resources Institute for Drug Education (PRIDE) Canada Inc. 10th Annual Conference on Youth and Drugs: "PRIDE" of the Nation**
Winnipeg
FRONTLINE Associates, PRIDE Conference Coordinators, 676 Borebank St., Winnipeg MB R3N 1G2; tel and fax 204 489-2739

**May 27, 1995: Canadian Fertility and Andrology Symposium: Sexuality, Fertility and Menopause (copresented by the Canadian Fertility and Andrology Society)**
Niagara-on-the-Lake, Ont.
Continuing Education, Faculty of Medicine, Rm. H121, Health Sciences, University of Western Ontario, London ON N6A 5C1; tel 519 661-2074, fax 519 661-3797

**May 27, 1995: Obsessive–Compulsive Disorder: New Developments in Treatment**
Toronto
*Study credits available.*
Education Office, Clarke Institute of Psychiatry, 250 College St., Toronto ON M5T 1R8; tel 416 979-2221, ext. 2643

**May 27–30, 1995: 3rd Annual International Conference on Diabetes and Indigenous Peoples — Theory, Reality and Hope (hosted by Canada through the Assembly of First Nations, the Assembly of Manitoba Chiefs and the S.U.G.A.R. Group)**
Winnipeg
Canadian Conference Planning Committee, 405–800 Portage Ave., Winnipeg MB R3G 0N4; tel 204 945-6831, fax 204 948-2190

**May 28–31, 1995: 5th National Home Care Conference: Teaming Up for Positive Outcomes (sponsored by the Canadian Home Care Association, the Alberta Home Care Association and the Edmonton Board of Health)**
Edmonton
Conference Secretariat, c/o the CanaGlobe Group Inc., 15016 77 Ave., Edmonton AB T5R 3B3; tel 403 487-8102, fax 403 487-2417

**May 28–June 1, 1995: 2nd International Heart Health Conference**
Barcelona, Spain
*Official language: English*
Pacifico, S.A., Enric Granados St. 44, 08008 Barcelona, Spain; tel 011 343 454-5400, fax 011 343 451-7438

[redacted]